No.

IN THE

Supreme Court of the United States

October Term, 1993

MARIO M. CUOMO, in his official Capacity as Governor of the State of New York; MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York; SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York; MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York; and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Petitioners,

against

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

G. OLIVER KOPPELL
Attorney General of the
State of New York
Attorney for Petitioners
120 Broadway
New York, New York 10271
(212) 416-8707

JERRY BOONE
Solicitor General

ANDREA GREEN
Deputy Solicitor General

JANE LAUER BARKER
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

**Counsel of Record*

26pp

QUESTION PRESENTED

1. Does section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) ("ERISA"), preempt New York's all-payor hospital reimbursement system, to the extent it does not charge all patients the same rates, because it may indirectly increase the cost of providing hospital care benefits for some ERISA plans?

PARTIES TO THE PROCEEDINGS

In accordance with Sup. Ct. Rule 14.1(b) the names of all parties in these consolidated cases appear in the caption of the opinion of the court of appeals, which is reproduced in the separately bound joint appendix to this petition. In addition to the parties that appear in the caption of this petition, the following parties appeared in the court of appeals, New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State. In accordance with Sup. Ct. Rule 29.1, petitioners state that they do not have a corporate parent, subsidiary, or affiliate.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioners Mario M. Cuomo, Governor of the State of New York; Mark Chassin M.D., Commissioner of Health of the State of New York; Salvatore R. Curiale, Superintendent of Insurance of the State of New York; Michael J. Dowling, Commissioner of Social Services of the State of New York; and G. Oliver Koppell, Attorney General of the State of New York[1] (hereafter referred to collectively as "New York"), respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit, entered in the above action on January 14, 1994.

OPINIONS BELOW

The amended opinion of the Court of Appeals for the Second Circuit is not reported and is reprinted in the appendix to the petition at A-1 to A-34.[2] The memorandum opinion of the United States District Court for the Southern District of New York (Freeh, D. J.) is reported at 813 F. Supp. 996 (S.D.N.Y. 1993) and is reprinted at A-63 to A-90.

JURISDICTION

The judgment of the court of appeals was entered on October 25, 1993. Subsequently the court of appeals granted a timely petition for rehearing by order dated January 12, 1994, and issued an amended opinion on January 14, 1994. This petition is filed within ninety days of the court's amended opinion. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

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[1] Michael J. Dowling succeeded Mary Jo Bane as Commissioner of Social Services on June 30, 1993. G. Oliver Koppell succeeded Robert Abrams as Attorney General of the State of New York on December 30, 1993. Both are automatically substituted pursuant to Fed. R. App. P. Rule 25(d).

[2] References to the joint appendix filed with the United States Court of Appeals for the Second Circuit are cited as (JA ___). References to the separately bound joint appendix are cited as (A -)

STATUTES INVOLVED

The applicable statutes are reproduced in the appendix at A-99 to A-113. The relevant federal statutory provisions are §§ 1144(a) and 1144 (b)(2)(A) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The relevant New York statutory provisions are New York Public Health Law ("PHL") § 2807-c.

STATEMENT OF THE CASE

New York's comprehensive regulation of hospitals includes the requirement that hospitals charge all patients according to a particular methodology, set forth at PHL § 2807-c. This case involves a challenge to three separate payor differentials contained within New York's regulatory scheme. The court of appeals held the differentials are preempted by ERISA because they indirectly increase some ERISA plans' costs of providing benefits. As a result of this decision, New York's, and other states', ability to contain health care costs through hospital rate regulation is severely threatened.

A. Hospital Rate Regulation In New York And The 13% Differential

In 1988, New York instituted the New York Prospective Hospital Reimbursement Methodology ("NYPHRM III"), the rate-setting scheme at issue here. The system is based, in large part, on a case payment methodology by which hospitals are paid a certain amount for each patient treated. Each patient is assigned to one of 794 diagnostic related groups ("DRGs"). The rate charged for each DRG reflects the anticipated relative average amount of hospital resources required to treat a patient within the DRG (JA 477).[3]

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[3] A hospital DRG rate is the sum of different elements, an operating cost component, a capital cost component, a bad debt and charity care allowance, a trend factor for inflation, a factor reflecting medical (continued...)

Under NYPHRM III, hospital charges of patients covered by Medicaid, not-for-profit health services corporations ("Blue Cross plans") and health maintenance organizations ("HMOs") are calculated at the case payment rate for the DRG to which the patient is assigned, PHL § 2807-c(1)(a). Hospitals are required to charge patients covered by workers' compensation insurance, the volunteer firefighters benefit system, the "no fault" motor vehicle insurance system, commercial health insurance carriers and self-insured funds who make payments directly to hospitals, 113% of the applicable DRG rate, with a 2% discount for prompt payment, PHL § 2807-c(1)(b).

A patient who does not fall within either of these categories, for example, "self-pay" patients and patients covered by self-insured funds that do not make direct payments to hospitals, are in a third category and are billed charges, *i.e.*, prices for the particular hospital services rendered to them. The charges may not exceed approximately 131% of the DRG rate that would otherwise apply, PHL § 2807-c(1)(c).

ERISA plan participants fall within all three payor categories depending on the type of health care coverage utilized by the plan.[4] ERISA plan participants who have Blue Cross or HMO coverage are charged the DRG rate. ERISA plan participants who have commercial insurance coverage or are covered by a self-insured fund that makes payments to the hospital directly are charged 113% of the DRG rate. ERISA plan participants who are covered by a self-insured fund that does not make payments directly to the hospital are billed charges that cannot exceed 131%

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[3](...continued)
malpractice costs, and excess medical malpractice costs. Some hospitals' DRG rates also include a financially distressed hospital adjustment. The rates for the same DRG vary from hospital to hospital since much of the cost data used to compute a hospital's DRG rates are derived from that hospital's unique cost history and particular capital costs (JA 477-8).

[4] Moreover, all payor categories cover patients who are ERISA plan participants and others who are not ERISA plan participants.

of the DRG rate. Although the hospital's reimbursement for treating a patient depends, in part, on the type of health care coverage involved, the law does not require any ERISA plan or third party payor to pay any benefit, any level of benefit, or any particular amount towards a patient's hospital charges (JA 483-4).

Although the DRG methodology for calculating hospital bills was new in 1988, the 13% charge differential in favor of government payors, Blue Cross and HMOs was not. Prior to the 1960's, when hospital rates were not regulated in New York, it was a common practice of hospitals to negotiate rates with Blue Cross plans that were a certain percentage less than their published charges (JA 642-3, 664). By the late 1970's, the rates New York hospitals charged for treating patients who were covered by Medicare, Medicaid, Blue Cross and HMOs were regulated by federal and state cost control laws. Hospitals, on their own initiative, billed patients who were covered by other payors, including commercial insurers, charges which were 25% to 40% higher than the rates paid by the regulated payors (JA 472-4, 642-5).

In 1983, New York implemented its first all-payor hospital reimbursement system, which included a uniform but reduced differential. The rates hospitals charged patients covered by Medicaid, Medicare, HMO, and Blue Cross were to be computed as a uniform average per diem rate for each day of care rendered to an eligible patient (JA 475). All other patients, including those covered by commercial insurers, were "charge payors" and hospitals were required to set their charges uniformly at a level not exceeding 115% of the Blue Cross rate. As a result of this comprehensive rate setting scheme, the hospital bills of patients covered by commercial insurers were reduced from what they had paid prior to 1983 by 8% to 18% (JA 473-5).

B. The 11% Surcharge

In 1992, the New York Legislature amended PHL § 2807-c to require an additional 11% surcharge, to be added on to the hospital bills of patients covered by commercial insurance for a

one year period ending March 31, 1993, PHL § 2807-c(11) (i). [5] Hospitals were required to pay this money into a statewide pool, which was then paid over to the State's General Fund, PHL § 2807-c (14-e).

The 11% surcharge was enacted primarily to remedy the deterioration in the Blue Cross plans' financial position and its effect on the State's health care system (JA 649-50). It was also intended to raise revenue for the State. The enactment of the 11% surcharge followed repeated studies by the State of the social efficacy of discounted rates for the Blue Cross plans. Studies in 1958, 1965, and 1984 had concluded that the discount was justified both by the prepayment policies of the Blue Cross plans and by their policy of open enrollment which ensured that many more individuals were able to obtain health insurance (JA 658-670).

In 1988, the New York State Department of Insurance ("DOI") concluded that the Blue Cross plans needed the differential to ensure continued enrollment of those least able to afford health insurance coverage and that Blue Cross plans' differential had to be large enough to keep better risks (JA 648). The DOI called upon the Legislature to take action to assist Blue Cross plans in competing with commercial insurers who were choosing to insure only the healthiest customers, keeping their rates down and leaving Blue Cross plans with the poorest risks (JA 649-50). After 1988, the Blue Cross plans faced continuing shrinkage of their community-rated pools and increasing underwriting losses.

Proposals to address the deteriorating competitive position of the Blue Cross plans were enacted in 1992, to become effective April 1, 1993. Certain provisions, not challenged here, required community-rating and open enrollment by insurers. The 11% surcharge, to be assessed upon hospital bills paid by commercial insurers until the effective date of the new law, was enacted in a separate bill (JA 651). Commercial insurers asserted in the

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[5] The challenge to the 11% surcharge is not moot since the respondents refused to pay it. The money was paid into escrow. (JA 66).

litigation that their increased costs would lead to increased costs for their insureds, including ERISA and non-ERISA plans (JA 388-9).

C. The HMO Assessment

In 1992, The New York Legislature also provided for a third differential, a contingent assessment of up to 9%, on the hospital bills of non-Medicaid patients who are enrolled in HMOs. The primary purpose of this amendment was to encourage HMOs to enter into "managed care contracts" with local social services districts and to enroll a target number of Medicaid recipients, thereby lowering the cost of the Medicaid program (JA 761). The assessment is eliminated if an HMO becomes a managed care provider and enrolls at least 90% of a target number of Medicaid-eligible persons. The 9% assessment is reduced by 25%, 50% or 75%, if the HMO enrolls a like percentage of its target number of Medicaid-eligible persons (JA 760). The revenue is payable by HMOs on a monthly basis into a statewide HMO pool and credited to the State's general fund (JA 759-60). HMOs indicated they would raise their rates, passing the costs of this assessment on to their subscribers, including ERISA and non-ERISA plans (JA 1553).

D. Prior Proceedings

On June 2, 1992, the Travelers Insurance Company ("Travelers") commenced this action challenging the 13% differential and 11% surcharge contained in PHL § 2807-c as preempted by ERISA (JA 54).[6] On August 10, 1992, the Health Insurance Association of America ("HIAA") and several insurance companies and trade associations commenced an action challenging the 9% assessment, the 13% differential, and 11% surcharge as

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[6] The discussion of the prior proceedings is limited to those issues on which New York is petitioning for a writ of certiorari.

preempted by ERISA. (JA 101).[7] The parties moved and cross-moved for summary judgment on all claims (JA 168, 333, 454, 767, 1235, 1358).

On February 3, 1993, the district court issued a decision and order holding that the 13% differential, 11% surcharge, and the 9% HMO assessment are preempted by ERISA because they "lead, indirectly, to an increase in plan costs" (A-71). While recognizing that none of the state laws had a direct effect on the structure or administration of ERISA plans, the court nevertheless held that the indirect economic impact may affect the structure and administration of plans by encouraging plans to reduce the level of benefits, a result "which ERISA was designed to avoid" (A-74). The district court acknowledged that its decision meant that states are precluded from regulating hospital rates of patients who are covered by ERISA plans, but stated that any argument about this consequence must be directed at Congress, not the courts (A-78). The district court also held that none of the challenged provisions were within ERISA's insurance saving clause, which exempts from preemption laws regulating insurance, 29 U.S.C. § 1144(b)(2)(A). On February 9, 1993, the district court stayed its judgment as to the 13% differential and required that the 11% surcharge and the 9% differential be paid into escrow (A-98).

On October 25, 1993, the United States Court of Appeals for the Second Circuit affirmed the district court's holding that the three surcharges relate to ERISA plans because they impose a significant economic burden on commercial insurers and HMOs, thereby having an impermissible impact on the structure and administration of ERISA plans (A - 24).

The court of appeals found that the 13% and 11% differentials were designed to increase hospital costs for patients covered by

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[7] The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York intervened as parties-defendants (JA 82, 93). The New York State Health Maintenance Organization Conference and several HMOs intervened as parties-plaintiffs (JA 165).

health plans other than Blue Cross and, therefore "obviously" affect ERISA plans' health care benefits. Likewise, the court held that the 9% assessment increased the cost of HMO coverage, interfering with an ERISA plan's selection of the most effective way to provide benefits. This interference, the court found, was sufficient to constitute a connection with ERISA plans (A22-23).

The court of appeals also held a connection existed because the surcharges substantially increase the cost to ERISA plans of providing a given level of health care benefits. The court expressly rejected the argument of New York and the United States Department of Labor, which appeared as *amicus curiae*, that indirect economic impact, standing alone, does not justify preemption, (A-23) and held that substantial economic burdens had sufficient connection to plans to bring the preemption clause into play. The Second Circuit also expressly refused to follow the Third Circuit, (A-24 nt. 3) which, in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3rd Cir.), *cert. denied*, _ U.S. _, 144 S.Ct. 382 (1993), held that a similar hospital rate statute's "indirect ultimate effect of increasing plans costs" places it beyond the scope of ERISA preemption. *Id.* at 1193.

The court of appeals also rejected New York's argument that the 11% surcharge was saved from ERISA preemption because it was a state law regulating insurance. The court held the 11% surcharge did not come within the common sense meaning of the term "regulates insurance" because it regulated hospital rates (A-26). As to the three McCarran-Ferguson factors, the court held the surcharge met only one - it affected the transfer or spreading of a policyholder's risk by encouraging plans to switch to Blue Cross (A-28). It did not regulate any practice that is integral to the insurer-insured relationship, nor was it limited to entities within the insurance industry and, therefore, was not saved from ERISA preemption (A-29).

On November 8, 1993, New York filed a timely petition for rehearing asking the court of appeals to decide an issue which had been overlooked in its opinion, whether the differentials were

preempted by the Federal Employee Health Benefits Act, 5 U.S.C. § 8901 *et seq.* (FEHBA). The court granted the petition for rehearing January 12, 1994, and issued an amended decision on January 14, 1994, holding that FEHBA preempted the differentials. The court did not alter its ERISA analysis.

REASONS FOR GRANTING THE WRIT

A. The Decision Of The Second Circuit In This Case Misreads Supreme Court Precedent and Is In Direct Conflict With A Decision Of The Third Circuit

The Second Circuit's decision is in direct conflict with the Third Circuit's decision in *United Wire, Metal, & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3rd Cir. 1993), *cert. denied*, __ U.S. __, 113 S.Ct 382 (1993), which held that certain surcharges, including a 13.2% payor differential, contained in New Jersey's hospital rate-setting scheme were not preempted by ERISA. Although the Second Circuit acknowledged this conflict, it reached the result it did by expansively interpreting the scope of this Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), expressly noting in its decision that the Third Circuit had read ERISA's preemption clause too narrowly (A-24). The Second Circuit also expressly rejected the United States Department of Labor's position that indirect economic effect, even if substantial, is not enough to trigger ERISA preemption (A-23). No decision of this Court, or of any of the other circuit courts of appeal, has made

economic impact a litmus test for ERISA preemption.[8] This Court should grant the petition to resolve this conflict.

The Second Circuit's decision is based upon an overly broad reading of this Court's determination in *Ingersoll-Rand* that a state law may relate to a benefit plan even if its effect is only indirect. *Id.* at 139. Relying on that language, the Second Circuit concluded that a law of general application, which neither refers to nor is directed at ERISA plans, may be preempted because of indirect economic effect which, if substantial, is enough to satisfy the "connected to" test of *Ingersoll-Rand*. (A-22). However, this Court has never held that all laws with indirect effects on ERISA plans relate to those plans. Nor has it developed a test to determine when indirect effects may be enough to relate to plans and when they are too remote and tenuous to relate to plans.

Moreover, this Court's analysis in *Ingersoll-Rand* does not support the Second Circuit's interpretation of that case. In *Ingersoll-Rand*, this Court was careful to analyze the effect of the state law at issue upon plans in light of the purpose of ERISA's preemption provision. As noted by this Court in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 7-10 (1987), the Congressional purpose in enacting a broad preemption provision is to allow ERISA plans to establish uniform administrative schemes to guide the processing of claims and benefits. Thus, in *Ingersoll-Rand*, this Court was concerned that, absent preemption of the state law cause of action, ERISA plans and plan sponsors would be subject to different substantive standards applicable to employer conduct

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[8] Although the Second Circuit cited *E-Systems Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991), *cert. denied sub. nom. Barnes v. E-Systems*, __ U.S.__, 112 S. Ct. 585 (1991), as a case where economic impact alone was enough to "relate to" ERISA plans, that case was very different. It involved a challenge by a self-insured plan to a tax specifically imposed on persons rendering any service to any "employee-employer health benefit plan". The statute held the plan ultimately liable for the payment of the tax. Thus, the law's relation to ERISA plans was not merely an indirect economic one. It was directed at, and almost exclusively concerned with, ERISA plans.

that would require tailoring plans differently in different states. 498 U.S. at 142. Also, in *Ingersoll-Rand* this Court was careful to note that it was not dealing with a law of general application that makes no reference to and indeed functions irrespective of the existence of ERISA plans. 498 U.S. at 139. The Second Circuit did not focus on the types of concerns that preemption was enacted to address, nor did it specifically analyze whether an indirect economic impact test would further plan uniformity.[9]

In contrast, in *United Wire*, the Third Circuit's preemption analysis focused on whether the rate setting statute's impact on plans raised the types of concerns that prompted preemption. 995 F.2d at 1193-95. The Third Circuit concluded that, given Congressional concern about plan uniformity, a state law with only an indirect impact on ERISA plans may be preempted if its effect is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting, and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states. *Id.* at 1193. However, the court held that the "mere fact that the statute has some economic impact on the plan does not require the statute be invalidated." *Id.* at 1195.

Applying this standard to New Jersey's rate setting scheme, the court found that it did not relate to plans:

> New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. This will mean that for any plan which commits to pay all or some lesser percentage of a participant's hospital costs will be called upon to pay more in benefits than it otherwise would. ... New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way.

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[9] The Second Circuit did note that increased cost would interfere with a plan's choice of the most effective method to provide benefits (A-22). In addition, it would force a plan to increase costs or reduce benefits (A-23).

> Nor does it deprive ERISA plans of any alternative they would otherwise have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Id. at 1193.

The Third Circuit held that *Ingersoll-Rand* did not require a different result. *Id.* at 1194. It construed *Ingersoll-Rand* in the factual context in which it arose, a state law cause of action which was predicated upon the existence of an ERISA plan. *Id.* at 1195. The Third Circuit distinguished that from the factual situation before it, a generally applicable law that makes no reference to, and functions irrespective of, the existence of ERISA plans. *Id.*

An examination of the purpose of ERISA's preemption provision illustrates the soundness of the Third Circuit's decision, treating a state law which regulates the cost of a commodity, including hospital services, differently than a state law which imposes, directly or indirectly, substantive obligations upon plan conduct. The purpose of ERISA preemption is to eliminate conflicting and inconsistent regulation of benefit plans. 120 Cong. Reg. 29,197 (1974). The resulting uniformity of regulation would "help administrators, fiduciaries, and participants to predict the legality of proposed actions without the necessity of reference to varying laws." House Rep. No. 533, 93rd Cong., 1st Sess. 12 (1973). Thus, plans only have to look to federal law to determine if their conduct is legal. Uniformity is achieved by conforming conduct to substantive federal requirements or, if there are no substantive federal requirements, plans are free from regulation and may administer themselves in any manner they wish.

Unlike state laws which regulate conduct, either directly or indirectly, laws which regulate the price of hospital care do not interfere with plan uniformity. There is no federal hospital rate regulation. In the absence of state hospital rate regulation, plans

would not pay the same amount for hospital care in each state. Thus, while preemption of state laws which impose, directly or indirectly, substantive obligations on plans results in uniform obligations, preemption of state laws that regulate the cost of hospital care does not result in uniform costs. This Court should grant the petition to resolve this conflict in the circuits concerning the scope of ERISA preemption.

B. This Case Presents Substantial and Pressing Questions Of National Importance.

This case is one of exceptional importance because it involves two areas of national significance, health care and ERISA preemption.

1. The Second Circuit's decision in this case severely interferes with the states' ability to contain health care costs through hospital rate regulation.

Health care is a subject of increasing national concern. Indeed, cost containment in the health care field is one of the most significant and difficult issues facing our country today. States have a strong interest in this area which has been traditionally left to state control. *See Hillsborough County v. Automated Medical Lab, Inc.* 471 U.S. 707, 719 (1985). It is also an area of increasing state legislative activity. At least twenty-two states have health care regulation similar to one or more of the surcharges preempted in this case. *See* 138 Cong. Rec. S 13269 (Sept. 10, 1992). The regulatory scheme in each of those states is threatened by this decision.[10] *See, New England Health Care Employees,*

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[10] This action represents just one of several ERISA challenges to particular components of hospital reimbursement methodologies, as well as the right of states to set rates at all. Two actions pending in the Second Circuit are *Trustees of the Pension, Hospitalization, and Benefit Plans of the Electrical Industry, et al. v. Cuomo*, No. 92-CV-5589, (E.D.N.Y.) (challenging New York's bad debt and charity care

(continued...)

et al. v. Mount Sinai Hospital, et al., No. 292 CV 01012 (D. Conn. Feb. 25, 1994)(which relied upon the Second Court's decision in this case to hold that Connecticut's Uncompensated Care Pool, funded by an assessment on hospital revenues, was preempted by ERISA because it indirectly increased ERISA plans' costs of providing hospital care benefits).

New York's all-payor hospital reimbursement system was developed to contain hospital rates so as to make health care affordable while providing hospitals with necessary revenue to provide access to quality care. (JA 1255).[11] Without an all-payor system, hospitals would be free to shift the costs not reimbursed by regulated payors onto unregulated payors. Indeed, one of the very considerations which prompted New York to implement its first all-payor system in 1983 was the enormous cost-shifting onto commercial insurers and self-insured plans. The payor differentials and surcharge also further important state goals in the health care area including assuring the availability of affordable health insurance to the broadest extent possible.

Although the court of appeals avoided the issue, the district court recognized that its economic impact analysis may well preclude states from regulating hospital rates, at least those incurred by patients who are ERISA plan participants (JA 38). Indeed, such a result is the death knell for all-payor hospital reimbursement systems and presents significant obstacles to any state's ability to reduce spiraling health care costs.

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[10](...continued)
component of the DRG), and *Connecticut General Life Ins. Co., et al. v. Cuomo*, No. 93-3648 (S.D.N.Y.) (challenging New York's balance billing law and the right of the State to set rates). Another action pending in the United States District Court in Minnesota, is *Boyle, et al. v. Anderson*, No. 3-39-359 (D. Minn.) (which challenges a state's methodology of funding care to the uninsured and underinsured).

[11] The federal government has for years encouraged states to experiment with all-payor reimbursement systems. *See Rebaldo v. Cuomo*, 749 F.2d 133, 135-36 (2nd Cir.), *cert. denied*, 472 U.S. 1008 (1985).

The national legislative proposals for health care reform will not solve the enormous problems that the Second Circuit's decision creates for state hospital rate regulation. For instance, the major reform proposals pending before Congress, including the Administration's Health Security Act, do not include hospital rate regulation. Nor do they deprive the states of the ability to undertake such efforts. *See* "Key features of Competing Reform Plans," 8 Daily Labor Rep. (BNA) C-3 (Jan. 12, 1994). [12] Moreover, to the extent that any national health plan imposes health care budgets as a major cost control measure, states will actually be encouraged to implement hospital rate regulation as a cost control measure. The Court should grant the petition to resolve the uncertainty which this decision has created for hospital rate regulation.

2. The Second Circuit's adoption of an economic impact test for ERISA preemption threatens all types of state regulation outside the health care area.

The Second Circuit's adoption of an economic impact standard for ERISA preemption raises significant questions concerning the scope of ERISA preemption. The history of the preemption provision in this Court underscores its importance. Ten times in the last thirteen years this Court has granted certiorari to review lower court determinations concerning ERISA preemption.[13]

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[12] Although the Administration's Health Security Act proposes changes to ERISA, it does not eliminate ERISA, including § 514(a), for most plans. *See* Health Security Act, H.R. 3600, 103d Cong. (1993).

[13] *District of Columbia v. Great Wash. Bd. of Trade*, 506 U.S.__, 113 S. Ct. 580 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Franchise Tax Bd. v. Construction*

(continued...)

The breadth of the Second Circuit's decision makes this a case which merits this Court's review. No other court has interpreted the preemption provision so broadly. The Second Circuit's interpretation is at odds with the construction of the statute given by the United States Department of Labor, which has enforcement authority for ERISA.

Many types of state regulation have an indirect economic impact upon ERISA plans. Some state laws regulate the price of commodities which ERISA plans purchase. For example, ERISA plans that provide tuition assistance or scholarships pay for education at state universities, at state regulated prices. ERISA plans purchase utilities and pay sales tax on a whole host of items. Other state regulations, such as building codes or minimum wage laws, increase ERISA plans' costs more indirectly. In *United Wire*, 995 F.2d at 1196, the Third Circuit cited the example of medical waste disposal regulation. This regulation is now threatened by the Second Circuit's decision. For example, the application of New York City's real property tax to a building owned by an ERISA plan has been challenged on the basis that the tax has a substantial economic impact on the plan's finances with a corresponding negative impact on the plan's ability to provide benefits. *See, Matter of the American Federation of Musicians and Employers Pension Fund et al. v. Tax Commission of the City of New York*, No.351-92 (Sup. Ct. N.Y. Cty.)

In 1985, the Second Circuit warned that too expansive an interpretation of ERISA's preemption provision would result in "a charmed existence" for ERISA plans, *Rebaldo v. Cuomo*, 749 F.2d at 138-39. The adoption of a standard for preemption which requires only a showing of indirect, although substantial, economic impact creates this charmed existence and goes far beyond Congress' intention in enacting the preemption provision. This Court should grant the petition to review this important federal question.

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[13](...continued)
Laborers Vacation Trust, 463 U.S. 1 (1983); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

CONCLUSION

FOR THE FOREGOING REASONS,
THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE GRANTED.

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Respectfully submitted,

G. OLIVER KOPPELL
Attorney General of the
State of New York
Attorney for Petitioners
120 Broadway
New York, New York 10271
(212) 416-8707

JERRY BOONE
Solicitor General

ANDREA GREEN
Deputy Solicitor General

JANE LAUER BARKER
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

**Counsel of Record*